DECISION NO.  2011-HPA-158(b);2011-HPA-159(b);2011-HPA-160(b)
(Grouped File: 2012-HPA-G05)

In the matter of an application under section 50.6 of the Health Professions Act, R.S.B.C. 1996, c. 183, as amended, (the “Act”) for review of a complaint disposition made by an inquiry committee

BETWEEN: The Complainant
AND: The College of Physicians and Surgeons of BC
AND: A Physician
A Physician
A Physician
BEFORE: Michael J. Morris, Panel Chair
DATE: Conducted by way of written submissions concluding on October 19, 2012

APPEARING: For the Complainant: Self-represented
For the College: Sarah Hellmann, Counsel
For Registrants 1 and 2: Lindsay Johnston, Counsel
For Registrant 3 Self-represented

I DECISION

[1] Upon considering the application made by the Complainant and pursuant to section. 50.6 of the Act, it is my decision that the disposition of the Registrar which, pursuant to s.32(5) is considered to be a disposition of the Inquiry Committee, is confirmed.

II INTRODUCTION

[2] The Complainant had been treated for a serious eye disease which eventually led to loss of sight in her right eye. Her relationship with the original treating ophthalmologist ("Registrant 1") deteriorated to the point where their patient-physician relationship was terminated. A second ophthalmologist ("Registrant 2") commenced
treatment the Complainant, however the Complainant was dissatisfied with the recommended treatment and eventually registered a complaint to the College of Physicians and Surgeons of BC (the “College”) concerning both ophthalmologists. During the College’s investigation, the Complainant also complained about an ophthalmologist (“Registrant 3”) who had treated the Complainant from 1995 to 2004.

III BACKGROUND

[3] The Complainant first saw Registrant 1 on November 5, 2008 requesting a second opinion on difficulties she was having with her right eye. The Complainant advised Registrant 1 at this time that she had been under the care of another ophthalmologist but would not reveal the name of the ophthalmologist. Registrant 1 had difficulties obtaining a history from the Complainant and described the Complainant as “delusional”. Registrant 1 provided the Complainant with her diagnosis and requested to see her in one year or at any time concerns arise.

[4] The Complainant did not see Registrant 1 again until January 20, 2010 when she attended Registrant 1’s clinic complaining of pain and reduced vision in her right eye. At this time Registrant 1 diagnosed the Complainant as having subacute angle closure glaucoma in her right eye. The Record indicates that at the time of this visit, the Complainant was somewhat delusional and complained of ”bugs” infecting her eyes. The Registrant provided treatment to the Complainant and requested she return for a follow up visit in two weeks (12 February, 2010).

[5] The Complainant visited Registrant 1 on February 5, 2010 and it was found the pressure in the right eye had increased significantly. Registrant 1 performed an iridotomy at this time. The Complainant attended for a follow-up visit on February 10, 2010 and Registrant 1 found the pressure in the right eye was still significant. Registrant 1 requested the Complainant stop taking a topical steroid as she may have been experiencing a side effect from that medication. Registrant 1 also recommended that the Complainant required another iridotomy in a different location in the right eye. Appointments were made at this time for the procedure to be completed.

[6] On February 12, 2010 the Complainant contacted Registrant 1’s office and cancelled the appointment as she was in too much pain to attend. The Medical Office Assistant (“MOA”) in Registrant 1’s office phoned the Complainant back to reschedule the appointment but the Complainant refused.

[7] The Complainant phoned Registrant 1’s office again on February 16, 2010 and spoke to the MOA. She asked what Registrant 1 had done to her eye as she could no longer see. The MOA was unsuccessful in getting the Complainant to make a follow-up appointment, describing the Complainant as delusional.

[8] On February 27, 2010 the Complainant attended the emergency department at a local hospital. The Complainant was referred to ophthalmologist “A” who confirmed the diagnosis provided by Registrant 1, and encouraged the Complainant to follow-up with Registrant 1. Ophthalmologist “A” provided a letter to Registrant 1 outlining his findings, and also expressing concern that the Complainant may not return for the necessary follow up. Ophthalmologist “A” also referred the Complainant to another specialist,
ophthalmologist “B” who saw the Complainant and diagnosed her with advanced glaucoma OD.

[9] Registrant 1 became quite concerned over the state of the Complainant’s mental health, feeling that it was impairing her judgement regarding health care. Registrant 1 had been unable to obtain any contact information from the Complainant and contacted the Complainant’s family doctor and relayed her concerns. The following day, after receiving a phone call from her family doctor, the Complainant phoned Registrant 1 and provided her with the name of the Complainant’s daughter. Registrant 1 contacted the Complainant’s daughter and confirmed with her that the Complainant had a long standing psychiatric history. With the assistance of the Complainant’s daughter, Registrant 1 initiated a referral to mental health services. Registrant 1 also provided a report to the Complainant’s family physician outlining her concerns over the Complainant’s physical and mental health, and opining that it was too late to salvage the vision in the Complainant’s right eye.

[10] On March 15, 2010 the Complainant phoned the office of Registrant 1 requesting that her medical records be sent to her family doctor. The MOA who took the call, had difficulty trying to speak to the Complainant and described her as agitated and rambling in her speech. The MOA was also advised by the receptionist for the Complainant’s family doctor that although the Complainant requested the medical records from Registrant 1, she refused to sign the necessary release forms.

[11] Registrant 1 forwarded the records to the Complainant’s family doctor with the explanation that the Complainant had refused to sign the release forms, but had concerns that in her current mental state, it would most likely not be “informed consent” in any event. Registrant 1 released the records in an effort to not further upset the Complainant. The records were faxed to the Complainant’s family doctor on March 16, 2010.

[12] On March 29, 2010 the Complainant wrote a letter to Registrant 1 demanding the immediate release of her medical records, and wanted them forwarded to her home address.

[13] After receiving a threatening and disturbing phone message from the Complainant on April 22, 2010, Registrant 1 forwarded a letter to the Complainant advising her that she was terminating their physician-patient relationship. Registrant 1 also stated that as the Complainant had already sought the opinion and care of other ophthalmologists, there was no requirement for her to provide a referral to another ophthalmologist.

[14] On April 30, 2010 the Complainant forwarded another letter to Registrant 1 once again demanding her medical records be released. The Complainant also accused Registrant 1 of participating in a “horrendous crime and conspiracy.”

[15] On March 26, 2010 the Complainant attended an eye care centre outpatients clinic and saw ophthalmologist “C” who diagnosed the Complainant as having absolute glaucoma on the right eye due to chronic angle closure. Ophthalmologist “C” referred the Complainant on an urgent basis, to Registrant 2, an ophthalmologist, for
consideration of a laser diode cycloablation on her right eye to reduce the pain associated to the glaucoma.

[16] Registrant 2 saw the Complainant on March 30, 2010 and reviewed with the Complainant, the reasons why the Complainant had been referred to him. The Complainant voiced her concern that no other measures were being taken to save her eye, and requested that cataract surgery be performed to restore her vision. Registrant 2 performed a lengthy examination of her eye which confirmed the diagnosis by each previous ophthalmologist and provided the Complainant with his expert opinion as to her treatment options. The Complainant accused Registrant 2 of being part of a conspiracy that included Registrant 1 and all the other ophthalmologists involved in her treatment to date, in purposefully trying to make her blind. The Complainant insisted on cataract surgery and would not consider the treatment suggested by Registrant 2. Registrant 2 offered the opportunity for the Complainant to be seen by another ophthalmologist for another opinion, however this was turned down by the Complainant.

[17] The Complainant wrote two letters to Registrant 2 dated June 15, 2010 and July 19, 2010 denying that she has chronic angle closure glaucoma, and demanding he provide her proof of the diagnosis in the form of all medical reports he may have in his possession. The Complainant also denies seeing the ophthalmologist involved in her treatment and referral to Registrant 2. The Complainant had copied the letters to the College who in turn contacted the Complainant to ascertain if she was lodging a complaint against Registrant 2.

[18] The Complainant wrote back to the College with a very brief response stating that Registrant 2 did not comply with her request and that he was not the only one implicated. The College commenced their investigation and included both Registrant 1 and Registrant 2 as subjects of their investigation.

[19] In a letter dated December 9, 2010 the College notified the Complainant and advised that they had now received responses from Registrant 1 and Registrant 2, and premised upon the Complainant’s written submissions and other information they had gathered, were prepared to forward the information to the Inquiry Committee, subject to any further information the Complainant may want to submit.

[20] The Complainant submitted additional information to the College in the form of a letter dated December 22, 2010, bringing to their attention an incident that occurred in 1996 implicating Registrant 3, an ophthalmologist. The Complainant’s concern surrounded a letter dated August 23, 1996 that Registrant 3 had sent to another doctor describing a recent visit the Complainant had made to his office. Registrant 3 wrote that the Complainant had been into the emergency department at a hospital in 1995 complaining that silverfish had entered her eye, and was still convinced (at this office visit in 1996) that silverfish were agents of Satan and were still infesting her right eye. His letter explained that there were no specific abnormalities in either eye. The Complainant described Registrant 3’s comments as unethical, disgusting and unprofessional.

[21] The College provided their disposition to this matter in a letter to the Complainant dated August 30, 2011 stating that her complaint could not be substantiated, and that the care provided by the physicians involved was appropriate.
IV DISCUSSION AND ANALYSIS

[22] The Review Board’s function with respect to review applications is described under s. 50.6(5) of the Act, where we must conduct a review of the College disposition and must consider the adequacy of the investigation and/or the reasonableness of the disposition. While the review is on the record itself there are provisions for the Review Board to hear other evidence as reasonably required for a full and fair disclosure of all matters related to the issues under review.

[23] The Complainant is clearly in disagreement with the diagnosis of glaucoma and attributes the blindness in her right eye to the procedures done by Registrant 1. With respect to Registrant 2, the Complainant disagrees with the diagnosis and procedures recommended and persists in wanting cataract surgery performed. The complaint against Registrant 3 only surfaced after the Complainant received copies of medical records that dated back 15 years where she took offence to the contents of a report Registrant 3 provided to another doctor. The record indicates that Registrant 3 examined the Complainant at various times from 1995 until 2004.

[24] The Complainant, despite receiving copies of the record as well as independently receiving copies of other medical records, contests the diagnosis of Registrant 1 and Registrant 2, and believes that other records are in existence that would prove their diagnosis wrong. There is nothing in the record that supports this argument and the Complainant has submitted nothing to support her position on this matter. Contrary to the Complainant’s argument, I find the record proves otherwise as the diagnosis presented by each of the ophthalmologists involved in this matter, most of them independent of one another, arrive at the same conclusions.

[25] The record contains copies of letters from another specialist, ophthalmologist “D” that were provided to the Registrants and were in turn provided to the College to aid in their investigation. These letters indicate that examinations were done on the Complainant on May 19, 2010 and July 20, 2010 and both confirmed the diagnosis of angle closure glaucoma in her right eye.

[26] The Complainant’s written submissions to the College and this Review Board contained mostly irrelevant material to this matter. The information she did provide that may have had some bearing on this matter was vague and had no evidentiary value to support her argument that the treatment prescribed by Registrant 1 caused her to lose the sight of her right eye. The College was in contact with each of the Registrants involved in this matter as well as the ophthalmologists who were involved in the Complainant’s treatment and were in possession of all available records supporting the eye examinations and treatment recommendations.

[27] The degree of thoroughness required for investigations to be “adequate” depends on the circumstances. The law applying to the adequacy of an investigation was properly determined in Review Board Decision No. 2009-HPA-0001(a) – 0004(a), at paras. [97] and [98];

[97] A complainant is not entitled to a perfect investigation, but he or she is entitled to adequate investigation. Whether an investigation is adequate will depend on the facts. An investigation does not need to have been exhaustive in order to be adequate,
provided that reasonable steps were taken to obtain the key information that would have affected the Inquiry Committee’s assessment of the complaint.

[98] The degree of diligence expected of the College – what degree of investigation was adequate in the circumstances – may well vary from complaint to complaint. Factors such as the nature of the complaint, the seriousness of harm alleged, the complexity of the investigation, the availability of evidence and the resources available to the college will all be relevant factors in determining whether an investigation was adequate in the circumstances.

[28] With respect to the reasonableness of the decision of the Inquiry Committee, and similar to previous Review Board decisions, I look to Dunsmuir v. New Brunswick, [2008] 1 S.C.R. 190 at para.47 to provide guidance in respect to the issue of reasonableness:

In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

[29] The record put before me in this matter demonstrates that reasonable steps were taken by the College to obtain all available information, and their disposition is defensible in respect of the facts and the law.

V CONCLUSION

[30] For all of the reasons set out above, and applying the standards of section 50.6(5) to the Record and the additional written submissions provided by the Complainant, the College and the Registrants, I find the Registrar’s investigation was adequate and the disposition of the investigation reasonable.

[31] In making these decisions I have considered all of the information and submissions whether or not specifically reiterated herein.

“Michael J. Morris”

Michael J. Morris, Panel Chair
Health Professions Review Board
February 20, 2013